SERFF Tracking Number:	*CEUL-127145709*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*48616*
Company Tracking Number:			
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*FLEAP Application*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Family Life Insurance Company

Product Name: FLEAP Application	SERFF Tr Num: CEUL-127145709	State: Arkansas
TOI: H02I Individual Health - Accident Only	SERFF Status: Closed-Approved-Closed	State Tr Num: 48616
Sub-TOI: H02I.000 Health - Accident Only	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Leigh Floyd, Rebecca Podowski	Disposition Date: 04/29/2011
	Date Submitted: 04/28/2011	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 04/29/2011
	State Status Changed: 04/29/2011
Deemer Date:	Created By: Rebecca Podowski
Submitted By: Rebecca Podowski	Corresponding Filing Tracking Number:

Filing Description:

We are filing a new application to be used with our previously approved Accident-Only policy. The base policy form number is FLEAP-AR, and was approved on 4/6/2010. The new application form number is FLIC-ESAE-0511.

Family Life appreciates the Department's time in reviewing our application filing.

Company and Contact

Filing Contact Information

Rebecca Podowski,	rpodowsk@manhattanlife.com

SERFF Tracking Number:	*CEUL-127145709*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*48616*
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TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*FLEAP Application*		
Project Name/Number:	*/*		

10700 Northwest Freeway
Houston, TX 77092

713-529-0045 [Phone]

Filing Company Information

Family Life Insurance Company	CoCode: 63053	State of Domicile: Texas
10700 Northwest Freeway	Group Code: 1117	Company Type:
Houston, TX 77092	Group Name: Manhattan Insurance Group	State ID Number:
(800) 877-7705 ext. [Phone]	FEIN Number: 91-0550883	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	Arkansas Fees.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Life Insurance Company	$50.00	04/28/2011	47053846

SERFF Tracking Number:	*CEUL-127145709*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/29/2011	04/29/2011

SERFF Tracking Number:	*CEUL-127145709*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*48616*
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Product Name:	*FLEAP Application*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 04/29/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CEUL-127145709*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*48616*
Company Tracking Number:			
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*FLEAP Application*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

SERFF Tracking Number:	*CEUL-127145709*	*State:*	*Arkansas*
Filing Company:	*Family Life Insurance Company*	*State Tracking Number:*	*48616*
Company Tracking Number:			
TOI:	*H02I Individual Health - Accident Only*	*Sub-TOI:*	*H02I.000 Health - Accident Only*
Product Name:	*FLEAP Application*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/29/2011	FLIC-ESAE-0511	Application/ Enrollment Form	Application	Initial			FLIC-ESAE-0511.pdf

FAMILY LIFE INSURANCE COMPANY

[10700 Northwest Freeway, Houston, Texas 77092]

Application for: Enhanced Supplemental Accident Expense Policy

Requested Effective Date: _____

PART 1 - GENERAL INFORMATION

1. PERSONS TO BE COVERED

Name (Please PRINT Full Name)	Relationship	Gender	Date of Birth	Age	Height Ft. In.	Weight Lbs.	Social Security Number
1.	Applicant						- -
2.	Spouse						- -
3.	Child						- -
4.	Child						- -
5.	Child						- -

2. APPLICANT'S HOME ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Email Address: _____

3. PREMIUM PAYOR ADDRESS (if different than Applicant)

Premium Payor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

4. EMPLOYMENT INFORMATION (All adult applicants)

Employer's Name: _____

Occupation/Duties: _____

Spouse's Employer's Name (if applying): _____

Spouse's Occupation/Duties: _____

5. BENEFIT INFORMATION: Accident Policy

Benefit Amount: Medical Expense Benefit

❑ .5 Unit ❑ 1.0 Unit ❑ 1.5 Unit ❑ 2.0 Units

Plan Type: ❑ Individual ❑ Individual & Spouse ❑ Single Parent ❑ Family ❑ Child(ren) Only

Billing Method: ❑ Monthly Bank Draft ❑ Direct Bill ❑ List Bill

Billing Mode: ❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

6. OPTIONAL RIDER: Accident Disability Rider Yes ❑ No ❑

Occupation: ❑ Type 1 ❑ Type 2

Benefit Amount: Accident Disability Monthly Income Benefit

❑ .5 Unit ❑ 1.0 Unit ❑ 1.5 Unit ❑ 2.0 Units

Units elected for Optional Accident Disability Rider may be less than or equal to but cannot exceed the number of units elected for the Accident Policy.

7. BENEFICIARY

Name: _____

Relationship: _____

8. PRIMARY PHYSICIAN

Name: _____

Address: _____

Phone: _____

PART 2 - REPRESENTATION & QUESTIONS OF THE APPLICANT

		YES	NO
1.	Are all persons to be insured to the best of your knowledge and belief in good health and free from physical impairment or abnormality?	❑	❑
2a.	Is any person to be insured engaged in any hazardous sports or activities including racing, but not limited to parachuting, rodeo riding, mountain climbing, scuba diving or intend to do so?	❑	❑
2b.	Is any person to be insured a member/participant in a semi-professional or professional sport?	❑	❑
3a.	Have you had a driver's license suspended or revoked within the past 3 years?	❑	❑
3b.	Have you had a DWI or DUI within the past 3 years?	❑	❑
3c.	Is any person to be insured currently under treatment or has any person to be insured been under treatment for drug or alcohol abuse in the past 3 years?	❑	❑
4.	Are all persons to be insured ages 19 to 25 years old enrolled as a full time student in an accredited school or college?	❑	❑
5.	Is there any other health, accident or disability insurance in force on the proposed insured?	❑	❑
6.	Will the insurance applied for replace or change any existing insurance?	❑	❑

If YES, give name of Company and type of insurance: _____

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Family Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original. Requested Draft Date: _____

_____ X _____

Date — Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____

Name — Name of Employer

to deduct from my salary and pay to Family Life Insurance Company, [Houston, Texas], the monthly deposits as set forth below. Beginning with the month of, _____ 20 _____ $ _____ each month.

Month

_____ _____

Signature of Employee — Date

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A. I hereby authorize and request any physician, hospital, dentist, pharmacy, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Family Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in the circumstances permitted by state and federal law.

B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer, the Medical Information Bureau, Inc. ("MIB") or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Family Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photo-copy.

C. Family Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply.

D. This authorization will be valid from the date signed for a period of two and one half years.

E. I authorize Family Life Insurance Company to obtain an investigative consumer report on me.

Dated: _____ Dated at: _____

Signed X _____ Signed X _____

Signature of Proposed Insured — Signature of Spouse

APPLICANT'S STATEMENT

I hereby apply to Family Life Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. I understand that: (a) the policy of insurance I am now applying for will be issued solely upon the written answers to questions and information asked for in this application; (b) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance; and (d) no change to the policy will be valid until approved by an officer of the Company which must be noted on or attached to the policy. I have read, or have read to me, the completed application and realize policy issuance is based upon statements and answers provided herein and they are complete and true to the best of my knowledge and belief. I acknowledge I have received an Outline of Coverage for the policy applied for.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact or material thereto commits a fraudulent insurance act, which may be a crime as determined by a court of law.

I understand that if the Accident Disability Income Benefit Rider is elected, the maximum benefit per month will not exceed 60% of my gross monthly income.

Dated at _____ on _____ 20 _____ .

City, State & Zip — Month & Day

Signature of Applicant: _____ Signature of Spouse: _____

AGENT'S STATEMENT

I Certify: 1) That any information recorded by me is true and correct to the best of my knowledge and belief. 2) I have given an outline of coverage for the policy applied for to the Applicant. 3) This ❑ does ❑ does not replace other insurance.

Dated _____ on _____ 20 _____ .

City, State & Zip — Month & Day

_____

Agent Name (Print) — Agent Signature — Agent Number

SERFF Tracking Number:	*CEUL-127145709*	*State:*	*Arkansas*
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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	04/29/2011
Bypass Reason:	n/a		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	04/29/2011
Comments:			
see form schedule.			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	04/29/2011
Bypass Reason:	n/a		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	04/29/2011
Bypass Reason:	n/a		
Comments:			